Screening Guidelines

Healthcare providers assume responsibility for comprehensive breast and cervical cancer, cardiovascular, and diabetes screening services and must:

- ⊙ Have a medical supervisor/director to ensure that healthcare providers are competent and proficient in clinical screening services and related patient education and counseling and to ensure that professional credentials are current.

- ⊙ Provide pelvic examination, in conjunction with a Pap test and clinical breast examination by a healthcare provider and referral for screening and/or diagnostic mammogram as indicated per screening guidelines.

- ⊙ Provide and participate in patient education activities with assistance from EWM as needed or requested. The education/counseling includes: breast self-examination instruction, screening guidelines, risk factor information, recommendations for positive lifestyle changes and counseling on abnormal findings and necessary follow up.

- ⊙ Utilize laboratories and refer enrolled clients for mammography and breast ultrasound to an approved Referral Provider.

- ⊙ Provide or refer for colposcopy and colposcopy-directed biopsy of cervical lesions. These services shall be provided by a healthcare provider who has received specialized training in colposcopy and/or colposcopy-directed biopsy. Healthcare providers must refer enrolled clients to an approved Referral Provider.

- ⊙ Provide or refer for diagnosis and treatment of high-grade lesions to an OB/GYN.

- ⊙ Provide or refer for fine needle or cyst aspiration of palpable breast lumps or breast lesions apparent on mammography. These services shall be provided by an approved, licensed healthcare provider who has received specialized training in breast fine needle and/or cyst aspiration. Healthcare providers must refer enrolled clients to an approved Referral Provider.

- ⊙ Provide cardiovascular and diabetes screening as described in the Screening Guidelines Section. Discuss and advise clients with elevated cholesterol, blood pressure, blood glucose, or body mass index, based on their lab values, on strategies to reduce their risk factors and attain healthiest screening outcomes. See Cardiovascular Screening Protocols Section.

- Computer Aided Detection (CAD) is **NOT** reimbursable.
- Magnetic Resonance Imaging (MRI) is **NOT** reimbursable.

Who Can You Enroll & What Screening and Diagnostic Services Can They Receive?

ENROLLMENT	SCREENING SERVICES	DIAGNOSTIC SERVICES	ADDITIONAL SERVICES
Who can be enrolled?	**What screening services are available?**	**What diagnostic service can they receive?**	**After client is enrolled, what additional follow up services is she eligible for?**
Women 18 through 39 years of age who have a palpable breast mass suspicious for malignancy ***EWM highly encourages every client with a suspicious breast mass to be referred to a surgeon. The CDC recommends that every client 18 years of age and older with a suspicious clinical breast exam be referred to a surgeon.**	▪ NONE	▪ Surgeon may order imaging after consultation ▪ Breast Ultrasound ***(Must be preauthorized)*** **Reimbursement for breast ultrasound needs to be **preauthorized** for clients 18-39, except when recommended by a radiologist following a diagnostic mammogram in clients 30-39. Approval is based on funding availability.* ▪ Diagnostic Mammogram ***(Client must be at least 30)*** ▪ Fine Needle/Cyst Aspiration ▪ Ultrasound Guided Fine Needle/Cyst Aspiration ▪ Repeat Breast Exam ▪ Biopsy: ▪Needle Core w/ or w/out imaging ▪Mammotome ▪Open Incision/ABBI w/ or w/out imaging ▪Excision w/ or w/out imaging ▪ For cervical diagnostic services see the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 2, Page 3) (example of this form located in the Forms & Materials Section on Page 11-4)	▪ NONE
Women 40 and above not covered by Medicare Part B	▪ Pap Test biennially (every 2 years) ▪ Pelvic Exam in conjunction with clinical breast exam and/or Pap test ▪ Clinical Breast Exam (CBE) ▪ Teaching of Breast Self-Exam (BSE) ▪ Screening Mammography ▪ Blood Pressure according to guidelines ▪ Height, Weight and Waist Circumference according to guidelines ▪ Fasting lipids to include total cholesterol and HDL according to guidelines ▪ Fasting glucose according to guidelines ▪ A1c if previously diagnosed with diabetes according to guidelines ***(Services available according to screening services listed on Screening Visit Card)***	▪ Breast Ultrasound ▪ Diagnostic Mammography -Compression, Magnification, Additional Views, etc. ▪ Fine Needle/Cyst Aspiration ▪ Ultrasound Guided Fine Needle/Cyst Aspiration ▪ Repeat Breast Exam ▪ Biopsy: ▪ Needle Core w/ or w/out imaging ▪Mammotome ▪Open Incision/ABBI w/ or w/out imaging ▪Excision w/ or w/out imaging ▪ For cervical diagnostic services see the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 2, Pg 3) (example of this form located in the Forms & Materials Section on Page 11-4)	▪ Follow up Pap test according to the 2006 ASCCP guidelines and with pre-authorization after abnormal Pap test/Colposcopy ▪ Follow up CBE ▪ Follow up Ultrasound ▪ Follow up Mammography **NOTE:** If 2006 ASCCP Guidelines indicate cytology at 6 months and 12 months or HPV testing at 12 months, EWM will **ONLY** pay for HPV testing at **12 months**.

Screening Visit

Clients 18-39 *(ENROLLED PRIOR TO JULY 1, 1997)*

Exams Clients Should Receive:	Paperwork the healthcare provider completes:	What you give the client:
1. Clinical Breast Exam 2. Teach/Review Breast Self Exam 3. Pelvic Exam * 4. Screening Pap test biennially (every 2 years)	1. EWM Screening Visit Card that the client brought with her. 2. Affix the Red and White sticker to the lab requisition for the Pap test evaluation so the lab will bill EWM. For clinics using electronic submission of lab requisition indicate EWM for billing purposes. Example Sticker: **Every Woman Matters** **1-800-532-2227** *(Example of Screening Visit Card located on page 3-5)*	1. No paperwork given to client at this time.

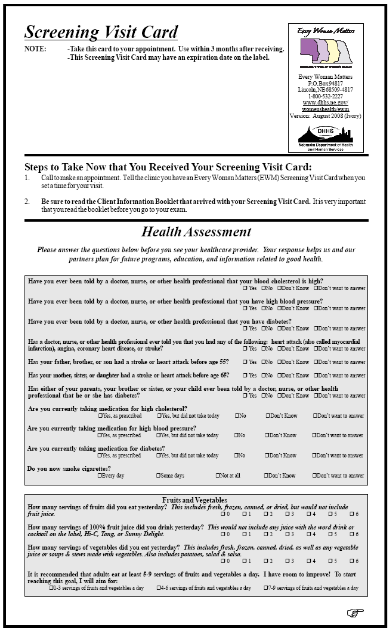
***** **Pelvic exam must be in conjunction with a Pap test and/or clinical breast exam in order to be reimbursed.**

NOTE: **Clients enrolled prior to July 1, 1997, will be issued Screening Visit Cards by EWM. No new client under 40 can be enrolled for screening.** ***(See Breast or Cervical Diagnostic Enrollment Guidelines on pages 2-2 through 2-4 for enrollment for diagnostic services)***

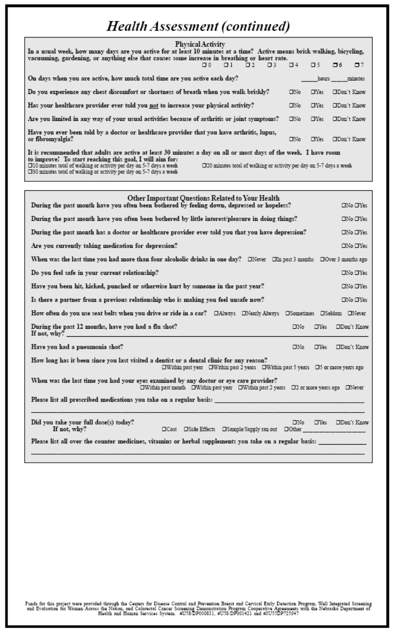
NOTE: **Screening mammography is not reimbursable for clients under the age of 40.**

Example of form for Screening Visit for Clients 18-39

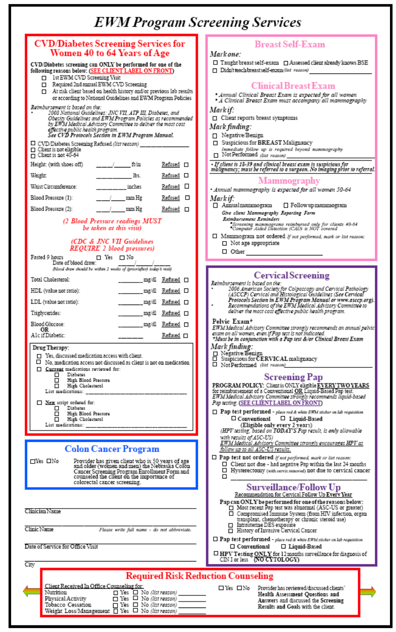
(enrolled prior to July 1997)



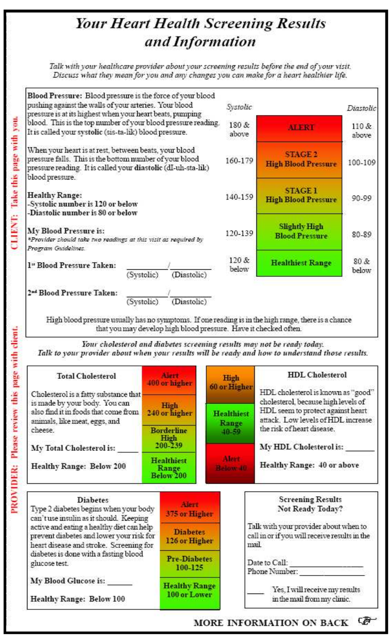
Client completes

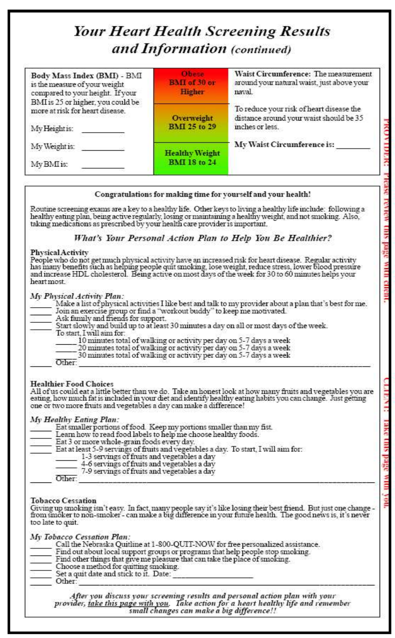


Client completes



Provider completes





Provider and Client completes these two pages together

Screening Visit Card (5 pages)

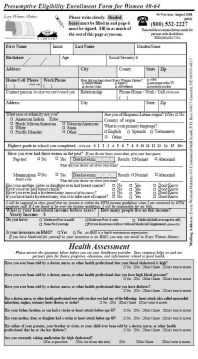
Screening Visit
Clients 40-64 Years

Exams Clients Should Receive:	Paperwork the healthcare provider completes:	What you give the client:
1. Clinical Breast Exam-Annually 2. Teach/Review Breast Self Exam 3. Mammography • 40-49: every 1-2 years at discretion of clinician • 50+: Annually 4. Pelvic Exam* 5. Screening Pap test biennially (every 2 years) 6. Blood pressure (two readings are required during visit)** 7. Fasting Lipid Panel or Basic Metabolic Panel to include total cholesterol and HDL timing in accordance with screening guidelines-see page 3-24** 8. Fasting blood glucose or A1c timing in accordance with screening guidelines-see page 3-18** 9. Weight, Height with shoes off, and Waist Circumference** 10. Risk factor evaluation based on the Health Risk Assessment on the Screening Visit Card**	1. Page 3 of Pink Enrollment or EWM Screening Card that the client brought with her. If cholesterol and glucose results are not immediately available, record when available. Submit Screening Visit Card to EWM within two (2) weeks of date of service. 2. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**). 3. Affix the Red and White sticker to the lab requisition for the Pap test evaluation so the lab will bill EWM. For clinics using electronic submission of lab requisition indicate EWM for billing purposes. Example Sticker: **Every Woman Matters** **1-800-532-2227** *(Example of Pink Enrollment and Screening Visit Card located on page 3-7)*	1. EWM Mammography Reporting Form (if mammogram ordered) (**gray shaded area must be completed by the healthcare provider**) for the client to take to an approved mammography facility. 2. Screening Visit Card (pages 4 and 5) for client to take with her. These two pages give the client and healthcare provider a place to write down the client's cardiovascular/ diabetes screening results. This is also a place for the client and healthcare provider to talk about goals to improve the clients' cardiovascular/ diabetes health. *(Example of EWM Mammography Reporting Form located on page 3-7)*

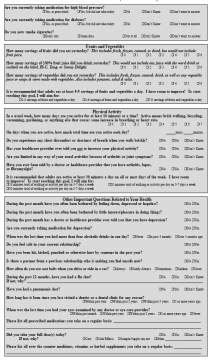
* **Pelvic exam must be in conjunction with a Pap test and/or clinical breast exam in order to be reimbursed.**

** **In order to be reimbursed for these exams, cardiovascular screening must be in conjunction with breast and cervical cancer screening and follow CVD Screening Guidelines set forth on page 3-18).**

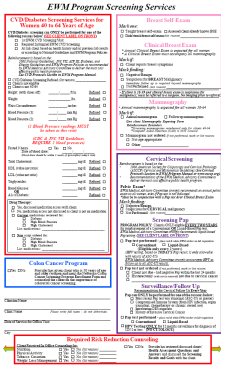
Example forms for Screening Visit for Clients 40-64



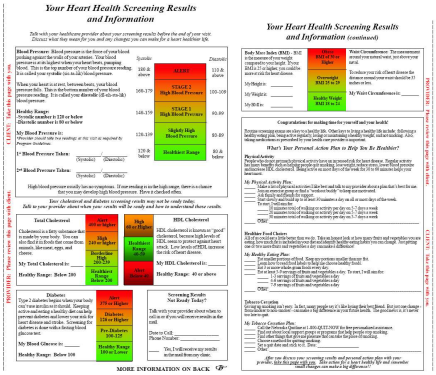
Client completes



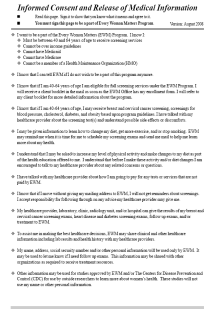
Client completes



Provider completes

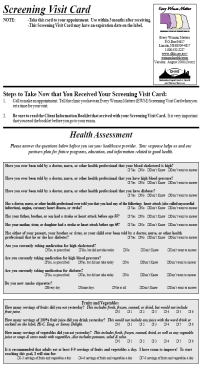


Client and Provider completes together

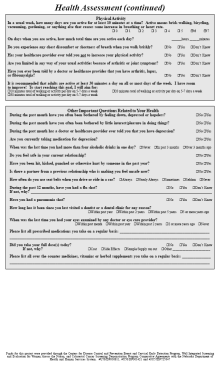


Client completes

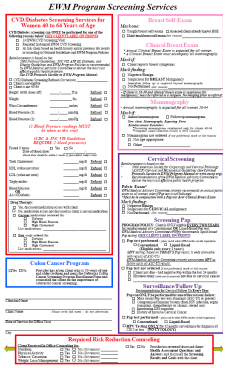
Presumptive Eligibility Enrollment Form (pink) (6 pages)



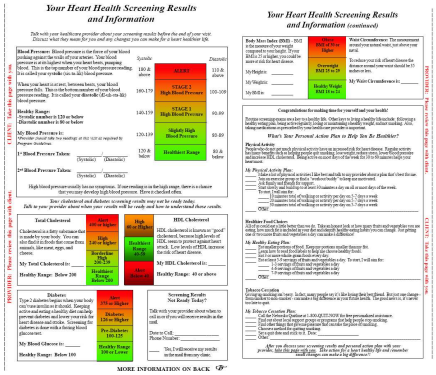
Client completes



Client completes

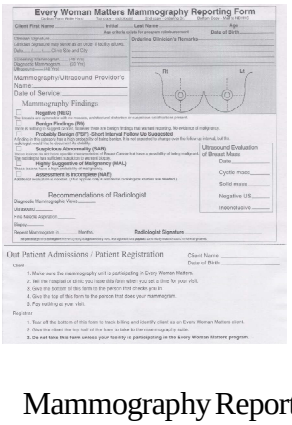


Provider completes



Client and Provider completes together

Screening Visit Card (5 pages)



Provider completes
gray shaded area

Mammography Reporting Form

Diagnostic Mammography

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Clients enrolling for diagnostic services, who are 30-39 years of age and who have a palpable mass suspicious for malignancy. ***EWM highly encourages every client with a suspicious breast mass to be referred to a surgeon.**	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 indicating referral to a surgeon) 2. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**)	1. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**) for the client to take to an approved mammography facility.
Clients of at least 40 years of age, who have had a mammogram indicating Assessment Incomplete.	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Sections 1 and 2) 2. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**). *(Example of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-9)*	1. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**) for the client to take to an approved mammography facility. *(Example of the EWM Mammography Reporting Form located on page 3-9)*

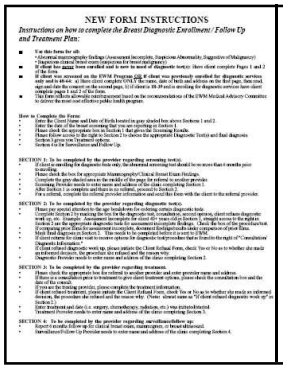
Breast Ultrasound

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Client is 18-39 years old with suspicious palpable mass **Reimbursement for breast ultrasound needs **preauthorization** for clients 18-39, **except** when recommended by a radiologist following a diagnostic mammogram in clients 30-39. **Preauthorization** for breast ultrasound is based on funding availability.*	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 and Preauthorization on Page 4) 2. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**)	1. Section 1 and 2 of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan for the client to take to an approved referring surgeon. 2. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**)
Client is 40 years old or older with suspicious breast malignancy on clinical breast exam with negative/ benign screening or diagnostic mammogram or Assessment Incomplete mammogram.	1. Complete Section 1 and 2 of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan 2. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**). *(Example of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-9)*	1. EWM Mammography Reporting Form (**gray shaded area must be completed by the healthcare provider**) for the client to take to an approved ultrasound facility. *(Example of the EWM Mammography Reporting Form located on page 3-9)*

NOTE: *Reimbursement for breast ultrasound needs **preauthorization** for clients 18-39, **except** when recommended by a radiologist following a diagnostic mammogram in clients 30-39. **Preauthorization** for breast ultrasound is based on funding availability.*

Example forms for Diagnostic Mammography and Breast Ultrasound

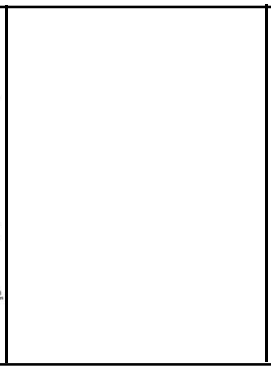
Breast Diagnostic Enrollment/Follow Up and Treatment Form (5 pages)



NEW FORM INSTRUCTIONS

Instructions on how to complete the Breast Diagnostic Enrollment / Follow Up and Treatment Plan:

Instructions for Providers



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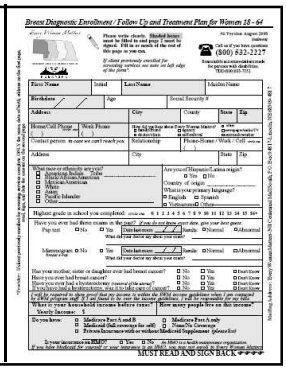
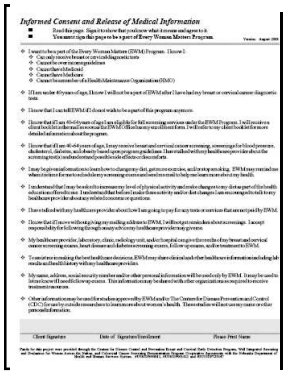


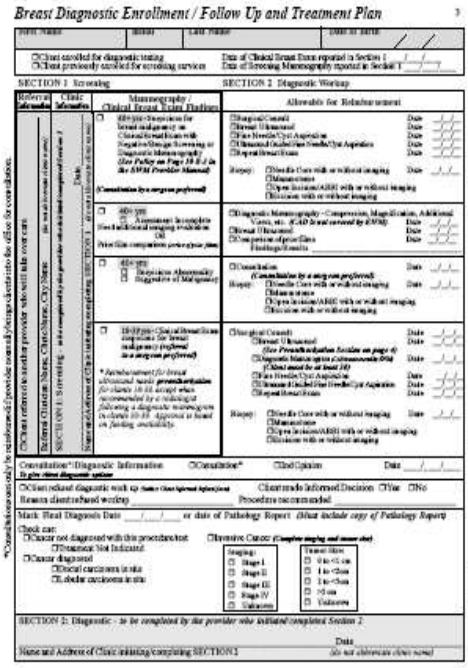
Breast Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

Client completes



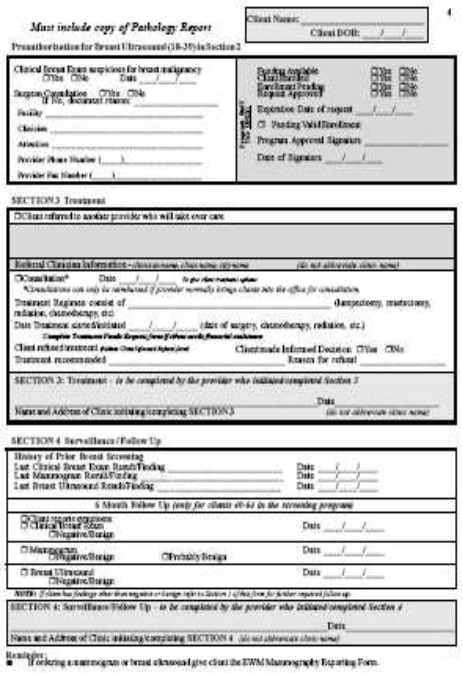
Informed Consent and Release of Medical Information

Client completes



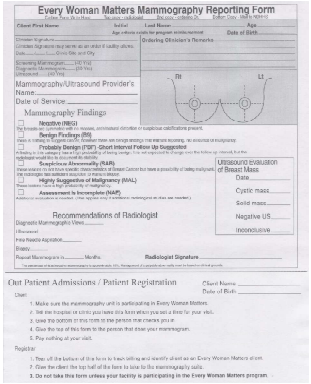
Breast Diagnostic Enrollment / Follow Up and Treatment Plan

Provider completes



Must include copy of Pathology Report

Provider completes



Every Woman Matters Mammography Reporting Form

Provider completes
gray shaded area

Mammography Reporting Form

Fine Needle or Cyst Aspiration

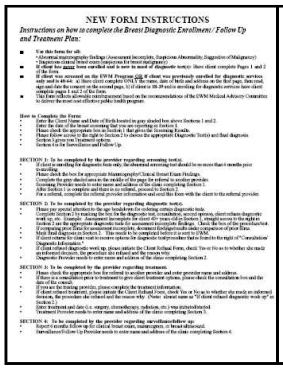
EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Client is 18-39 years old with suspicious palpable mass	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 indicating referral to surgeon)	1. If referring to another healthcare provider, give client the Breast Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider.
Client is 40 years old or older with suspicious breast malignancy on clinical breast exam with negative/ benign screening or diagnostic mammogram or assessment incomplete mammogram.	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 and 2) *(Example of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-11)*	1. If referring to another healthcare provider, give client Breast Diagnostic Enrollment/ Follow Up and Treatment Plan to take to an approved referral healthcare provider. *(Example of Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-11)*

Breast Biopsy

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Client is 18-39 years old with suspicious palpable mass	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 indicating referral to surgeon)	1. If referring to another healthcare provider, give client the Breast Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider.
Client is 40 years old or older with mammogram results of suspicious abnormality or suggestive of malignancy.	1. Breast Diagnostic Enrollment/ Follow Up and Treatment Plan (Section 1 and 2) *(Example of the Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-11)*	1. If referring to another healthcare provider, give client the Breast Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider. *(Example of Breast Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-11)*

Example forms for Fine Needle or Cyst Aspiration and Breast Biopsy

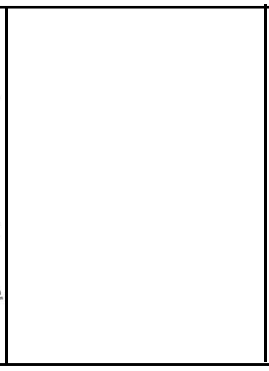
Breast Diagnostic Enrollment/Follow Up and Treatment Form (5 pages)



NEW FORM INSTRUCTIONS

Instructions on how to complete the Breast Diagnostic Enrollment / Follow Up and Treatment Plan:

Instructions for Providers



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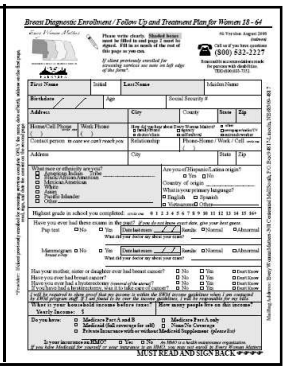
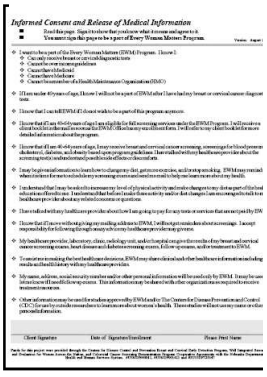


Breast Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

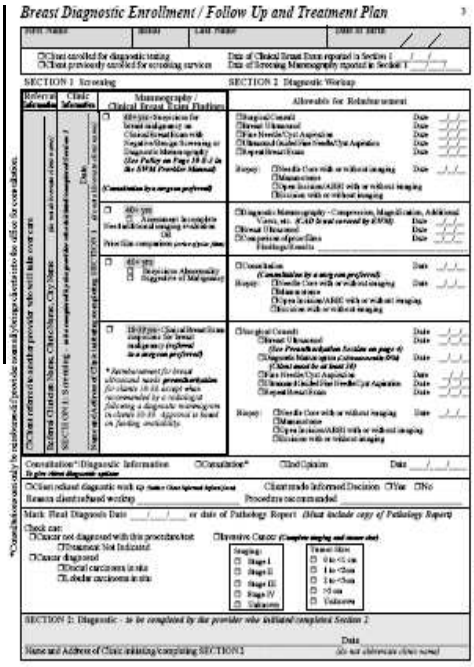
MUST READ AND SIGN BACK

Client completes



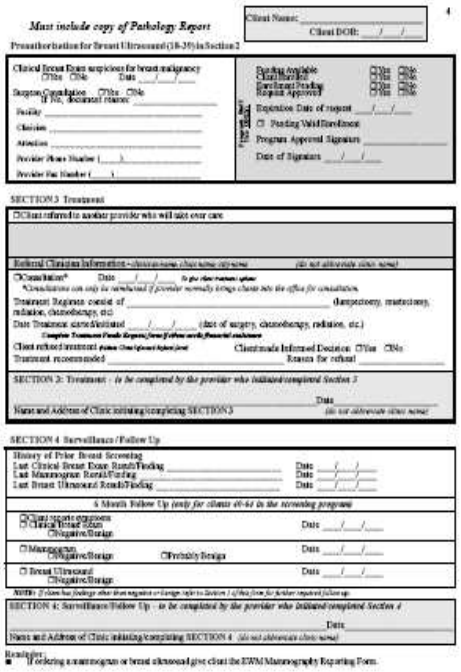
Informed Consent and Release of Medical Information

Client completes



Breast Diagnostic Enrollment / Follow Up and Treatment Plan

Provider completes

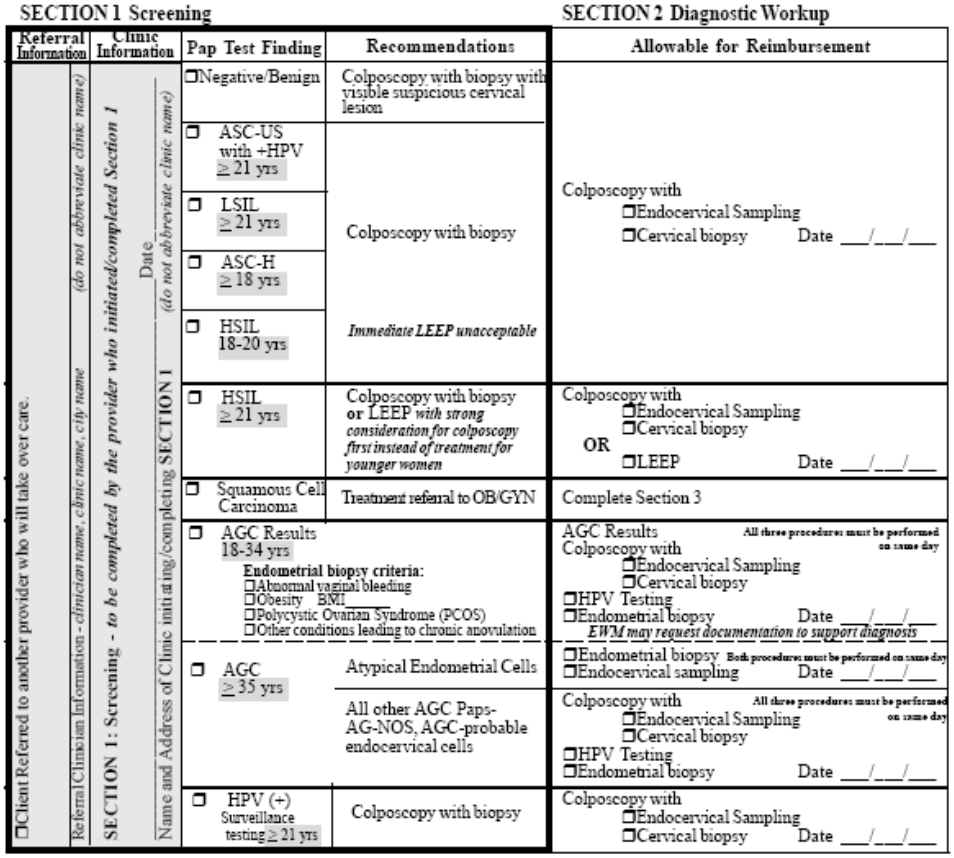


Must include copy of Pathology Report

Provider completes

Preauthorization - Pap Test for Short Interval Follow Up

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Preauthorization Before you contact EWM for pre-authorization, please check your request to confirm that it follows the 2006 ASCCP Guidelines. **Note:** If the 2006 ASCCP Guidelines indicate cytology at 6 months and 12 months **OR** HPV testing at 12 months, EWM will **ONLY** pay for HPV testing at 12 months. (See Policy 10 C-7). See algorithms in Cervical Protocols Section of this manual.	1. Cervical Diagnostic Enrollment/Follow Up and Treatment Plan **(Pre-authorization portion located in Section 4)** All Surveillance/Follow Up cytology and HPV testing at 12 months to be documented under Surveillance/Follow Up Section on the Annual Screening Visit Card. 2. Affix the Red and White Sticker to the lab requisition so the lab will bill EWM. For clinics using electronic submission of lab requisition indicate EWM for billing purposes. Example Sticker: **Every Woman Matters** **1-800-532-2227** *(Examples of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form are located on page 3-13)*	1. No paperwork given to the client at this time.

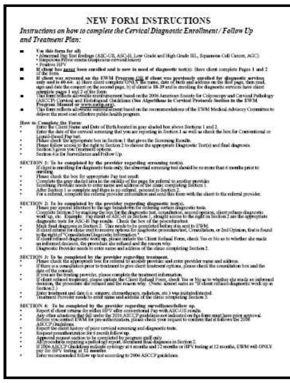


SECTION 1 Screening — SECTION 2 Diagnostic Workup

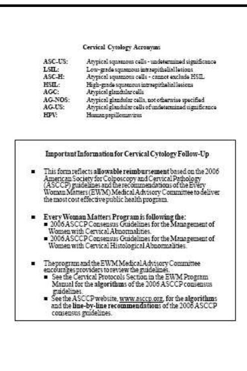
Referral Information	Clinic Information	Pap Test Finding	Recommendations	Allowable for Reimbursement
❒Client Referred to another provider who will take over care.	Referral/Clinician Information - *clinician name, clinic name, city name (do not abbreviate clinic name)* **SECTION 1: Screening - *to be completed by the provider who initiated/completed Section 1*** Date Name and Address of Clinic initiating/completing SECTION 1 *(do not abbreviate clinic name)*	❒Negative/Benign	Colposcopy with biopsy with visible suspicious cervical lesion	
		❒ ASC-US with +HPV ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy Date ___/___/___
		❒ LSIL ≥ 21 yrs		
		❒ ASC-H ≥ 18 yrs		
		❒ HSIL 18-20 yrs	*Immediate LEEP unacceptable*	
		❒ HSIL ≥ 21 yrs	Colposcopy with biopsy **or** LEEP *with strong consideration for colposcopy first instead of treatment for younger women*	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy **OR** ❒LEEP Date ___/___/___
		❒ Squamous Cell Carcinoma	Treatment referral to OB/GYN	Complete Section 3
		❒ AGC Results 18-34 yrs **Endometrial biopsy criteria:** ❒Abnormal vaginal bleeding ❒Obesity BMI ❒Polycystic Ovarian Syndrome (PCOS) ❒Other conditions leading to chronic anovulation		AGC Results *All three procedures must be performed on same day* Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy ❒HPV Testing ❒Endometrial biopsy Date ___/___/___ *EWM may request documentation to support diagnosis*
		❒ AGC ≥ 35 yrs	Atypical Endometrial Cells	❒Endometrial biopsy *Both procedures must be performed on same day* ❒Endocervical sampling Date ___/___/___
			All other AGC Paps-AG-NOS, AGC-probable endocervical cells	Colposcopy with *All three procedures must be performed on same day* ❒Endocervical Sampling ❒Cervical biopsy ❒HPV Testing ❒Endometrial biopsy Date ___/___/___
		❒ HPV (+) Surveillance testing ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy Date ___/___/___

Example forms for Pap Test for Short Interval Follow Up

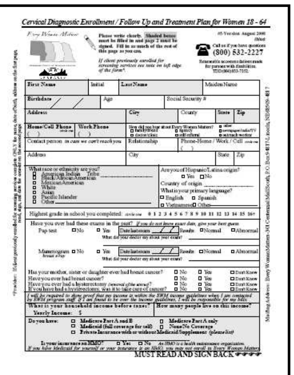
Cervical Diagnostic Enrollment/Follow Up and Treatment Form (6 pages)


NEW FORM INSTRUCTIONS
Instructions on how to complete the Cervical Diagnostic Enrollment / Follow Up and Treatment Plan:

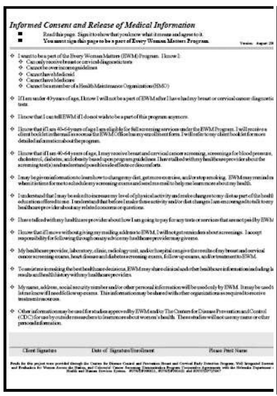
Instructions for Providers


Cervical Cytology Acronyms
Important Information for Cervical Cytology Follow-Up

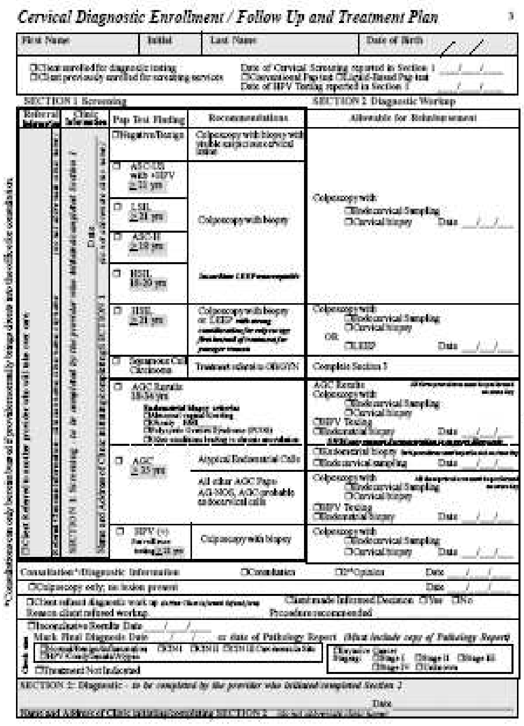
Provider Education


Cervical Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

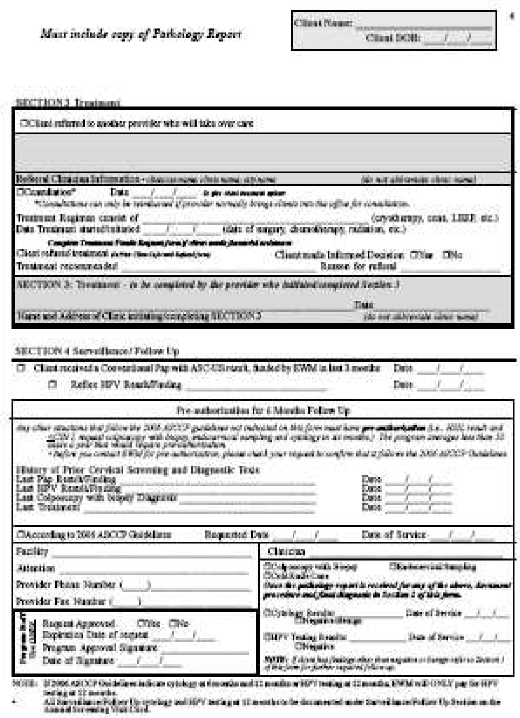
Client completes


Informed Consent and Release of Medical Information

Client completes


Cervical Diagnostic Enrollment / Follow Up and Treatment Plan

Provider completes


Must include copy of Pathology Report

Provider completes

Colposcopy and Colposcopy-directed biopsy

EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Services are allowable based upon the Cervical Diagnstic Enrollment/ Follow Up and Treatment Plan criteria listed below:	1. If referring or performing, complete Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 1 or 2). 2. Affix the Red and White Sticker to the lab requisition so the lab will bill EWM. For clinics using electronic submission of lab requisition indicate EWM for billing purposes. Example Sticker: **Every Woman Matters** **1-800-532-2227** *(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-15)*	1. If referring to another healthcare provider, give client the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider. *(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-15)*

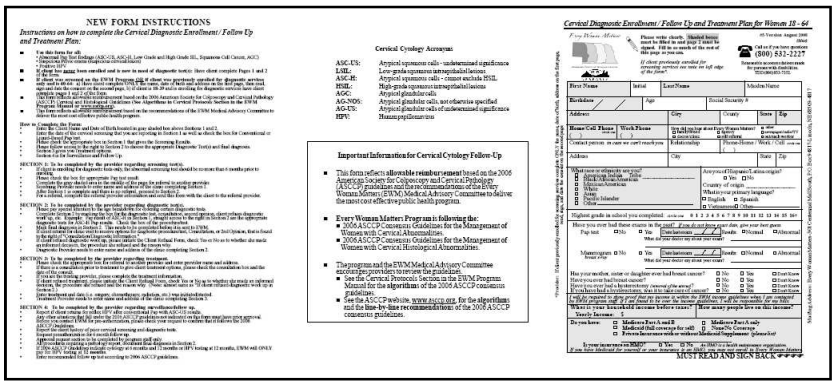
NOTE: Expect that 98% of clients receive colposcopy with biopsy.

SECTION 1 Screening — **SECTION 2 Diagnostic Workup**

Referral Information	Clinic Information	Pap Test Finding	Recommendations	Allowable for Reimbursement
❒Client Referred to another provider who will take over care. Referral Clinician Information - *clinician name, clinic name, city name* *(do not abbreviate clinic name)*	**SECTION 1: Screening** - *to be completed by the provider who initiated/completed Section 1* Date Name and Address of Clinic initiating/completing SECTION 1 *(do not abbreviate clinic name)*	❒Negative/Benign	Colposcopy with biopsy with visible suspicious cervical lesion	
		❒ ASC-US with +HPV ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy Date ___/___/___
		❒ LSIL ≥ 21 yrs		
		❒ ASC-H ≥ 18 yrs		
		❒ HSIL 18-20 yrs	*Immediate LEEP unacceptable*	
		❒ HSIL ≥ 21 yrs	Colposcopy with biopsy **or** LEEP *with strong consideration for colposcopy first instead of treatment for younger women*	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy **OR** ❒LEEP Date ___/___/___
		❒ Squamous Cell Carcinoma	Treatment referral to OB/GYN	Complete Section 3
		❒ AGC Results 18-34 yrs **Endometrial biopsy criteria:** ❒Abnormal vaginal bleeding ❒Obesity BMI___ ❒Polycystic Ovarian Syndrome (PCOS) ❒Other conditions leading to chronic anovulation		AGC Results **All three procedures must be performed on same day** Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy ❒HPV Testing ❒Endometrial biopsy Date ___/___/___ *EWM may request documentation to support diagnosis*
		❒ AGC ≥ 35 yrs	Atypical Endometrial Cells	❒Endometrial biopsy **Both procedures must be performed on same day** ❒Endocervical sampling Date ___/___/___
			All other AGC Paps- AG-NOS, AGC-probable endocervical cells	Colposcopy with **All three procedures must be performed on same day** ❒Endocervical Sampling ❒Cervical biopsy ❒HPV Testing ❒Endometrial biopsy Date ___/___/___
		❒ HPV (+) Surveillance testing ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy Date ___/___/___

Example forms for Colposcopy and Colposcopy-directed Biopsy

Cervical Diagnostic Enrollment/Follow Up and Treatment Form (6 pages)



NEW FORM INSTRUCTIONS

Instructions on how to complete the Cervical Diagnostic Enrollment / Follow Up and Treatment Plan:

Cervical Cytology Acronyms

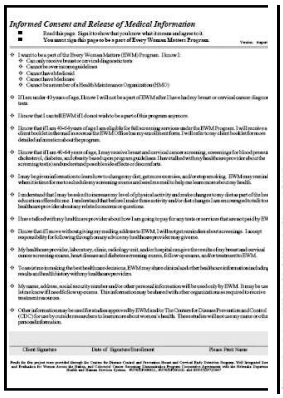
ASC-US:	Atypical squamous cells - undetermined significance
LSIL:	Low-grade squamous intraepithelial lesion
ASC-H:	Atypical squamous cells - cannot exclude HSIL
HSIL:	High-grade squamous intraepithelial lesions
AGC:	Atypical glandular cells
AG-NOS:	Atypical glandular cells, not otherwise specified
AG-EN:	Atypical glandular cells of endocervical significance
HPV:	Human papillomavirus

Important Information for Cervical Cytology Follow-Up

- This form reflects **allowable reimbursement** based on the 2006 American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines, the recommendations of the Every Woman Matters (EWM) Medical Advisory Committee to deliver the most cost effective public health program.
- **Every Woman Matters Program is following the:**
  - 2006 ASCCP Consensus Guidelines for the Management of Women with Cervical Abnormalities.
  - 2006 ASCCP Consensus Guidelines for the Management of Women with Cervical Histological Abnormalities.
- The program and the EWM Medical Advisory Committee encourages providers to review the guidelines:
  - See the Cervical Protocols Section in the EWM Program Manual for the **algorithm** of the 2006 ASCCP consensus guidelines.
  - See the ASCCP website, www.asccp.org, for the algorithms and the **line-by-line recommendations** of the 2006 ASCCP consensus guidelines.

Cervical Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

Instructions for Providers | Provider Education | Client completes

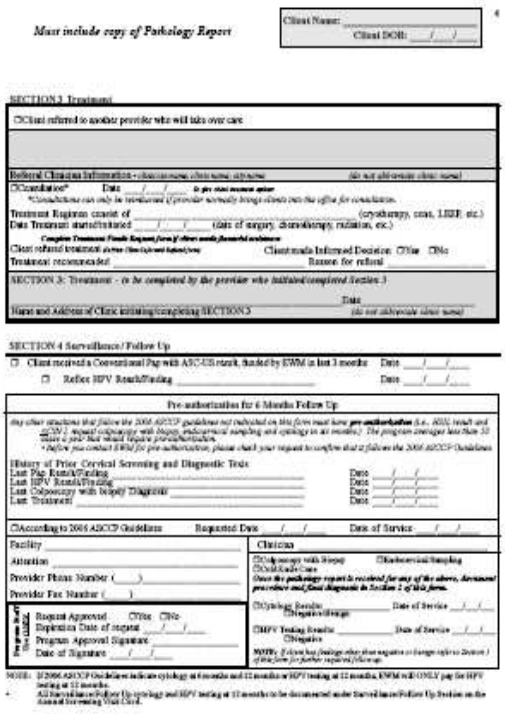


Informed Consent and Release of Medical Information

Client completes

Cervical Diagnostic Enrollment / Follow Up and Treatment Plan

Provider completes



Must include copy of Pathology Report

Provider completes

LEEP for Diagnosis

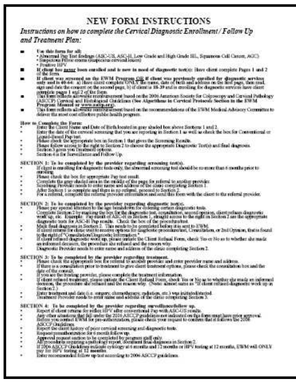
EWM will pay for this when:	Paperwork the healthcare provider completes:	What you give the client:
Procedure is performed, based upon the Cervical Diagnstic Enrollment/ Follow Up and Treatment Plan criteria listed below:	1. If referring or performing, complete Cervical Diagnostic Enrollment/Follow Up and Treatment Plan (Section 1 or 2). 2. Affix the Red and White Sticker to the lab requisition so the lab will bill EWM. For clinics using electronic submission of lab requisition indicate EWM for billing purposes. Example Sticker: **Every Woman Matters** **1-800-532-2227** *(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-17)*	1. If referring to another healthcare provider, give client the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan to take to an approved referral healthcare provider. *(Example of the Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form located on page 3-17)*

SECTION 1 Screening — **SECTION 2 Diagnostic Workup**

Referral Information	Clinic Information	Pap Test Finding	Recommendations	Allowable for Reimbursement
❒Client Referred to another provider who will take over care. Referral Clinician Information - *clinician name, clinic name, city name* *(do not abbreviate clinic name)* Name and Address of Clinic initiating/completing SECTION 1 *(do not abbreviate clinic name)*	**SECTION 1: Screening - *to be completed by the provider who initiated/completed Section 1*** Date ___	❒Negative/Benign	Colposcopy with biopsy with visible suspicious cervical lesion	
		❒ ASC-US with +HPV ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy Date ___/___/___
		❒ LSIL ≥ 21 yrs		
		❒ ASC-H ≥ 18 yrs		
		❒ HSIL 18-20 yrs	*Immediate LEEP unacceptable*	
		❒ HSIL ≥ 21 yrs	Colposcopy with biopsy **or** LEEP *with strong consideration for colposcopy first instead of treatment for younger women*	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy **OR** ❒LEEP Date ___/___/___
		❒ Squamous Cell Carcinoma	Treatment referral to OB/GYN	Complete Section 3
		❒ AGC Results 18-34 yrs **Endometrial biopsy criteria:** ❒Abnormal vaginal bleeding ❒Obesity BMI ____ ❒Polycystic Ovarian Syndrome (PCOS) ❒Other conditions leading to chronic anovulation		AGC Results **All three procedures must be performed on same day** Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy ❒HPV Testing ❒Endometrial biopsy Date ___/___/___ *EWM may request documentation to support diagnosis*
		❒ AGC ≥ 35 yrs	Atypical Endometrial Cells	❒Endometrial biopsy **Both procedures must be performed on same day** ❒Endocervical sampling Date ___/___/___
			All other AGC Paps- AG-NOS, AGC-probable endocervical cells	Colposcopy with **All three procedures must be performed on same day** ❒Endocervical Sampling ❒Cervical biopsy ❒HPV Testing ❒Endometrial biopsy Date ___/___/___
		❒ HPV (+) Surveillance testing ≥ 21 yrs	Colposcopy with biopsy	Colposcopy with ❒Endocervical Sampling ❒Cervical biopsy Date ___/___/___

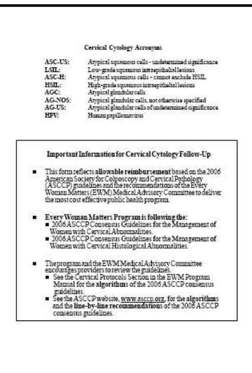
Example forms for LEEP for Diagnosis

Cervical Diagnostic Enrollment/Follow Up and Treatment Form (6 pages)


NEW FORM INSTRUCTIONS

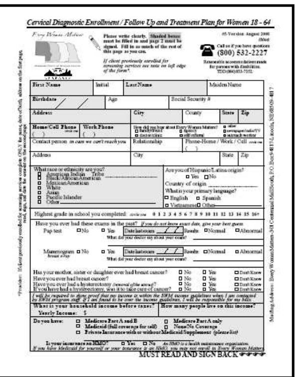
Instructions on how to complete the Cervical Diagnostic Enrollment / Follow Up and Treatment Plan:

Instructions for Providers

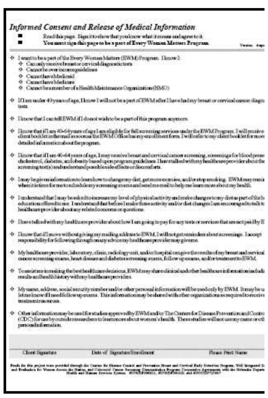

Cervical Cytology Acronyms

Important Information for Cervical Cytology Follow-Up

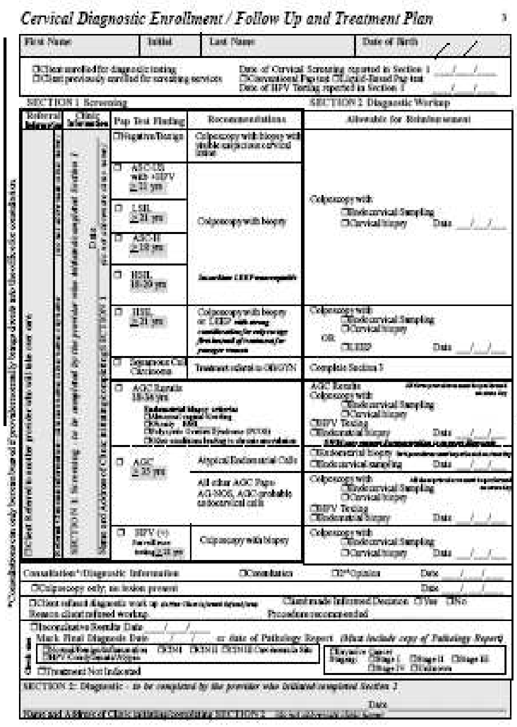
Provider Education


Cervical Diagnostic Enrollment / Follow Up and Treatment Plan for Women 18 - 64

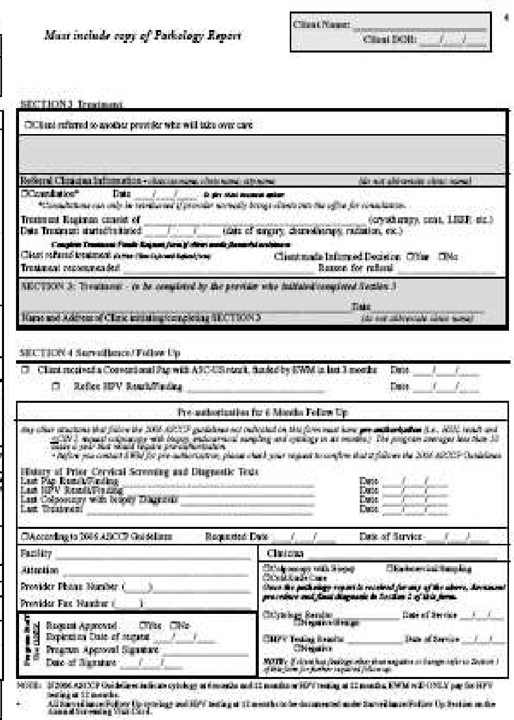
Client completes


Informed Consent and Release of Medical Information

Client completes


Cervical Diagnostic Enrollment / Follow Up and Treatment Plan

Provider completes


Must include copy of Pathology Report

Provider completes

Cardiovascular / Diabetes Screening

EWM CVD/Diabetes Screening services:	EWM will pay for this when:	Paperwork the healthcare provider completes:	Follow Up services:
1. Height/Weight Measurements 2. Two blood pressure readings 3. Waist circumference measurement 4. Total cholesterol test and HDL 5. Fasting blood glucose or an HgA1C test if client diagnosed diabetic	1. Client 40-64 is brand new to the EWM Program (never been enrolled or screened at anytime). Client is eligible to receive an initial CVD screening at her first breast and cervical visit. 2. Client 40-64 is eligible to receive a second required CVD screen at her next annual B&C visit (12-18 months after initial screening). 3. Client 40-64 and is at risk based on health history and/or previous lab results or according to National Guidelines and EWM Program Policies. **NOTE: Client Screening history on label on front of Screening Visit Card.**	1. Page 3 of the Screening Visit Card within the red box and the recommended goals to improve the clients' CVD/ Diabetes health. **The Screening Visit Card must be submitted to EWM in order to receive payment for the screening visit.** 2. Counsel the client on the healthcare provider's interpretation of the test results and the recommended treatment, including a review of all results, medications ordered, lifestyle modifications, interventions recommended, and accessible community resources.	1. Give client the "Heart Health Results and Information" (pages 4 and 5) from the Screening Visit Card to take with her. These two pages give the client and healthcare provider a place to write down the client's CVD/ Diabetes screening results. This is also a place for the client and healthcare provider to talk about goals to improve the clients' CVD/Diabetes health. *(Example of Screening Visit Card located on page 3-19)*

EWM does NOT pay for:

- Further diagnostic testing, such as a 12-lead EKG, stress test or other lab work not described in this manual.
- If services are needed that are NOT included on the list or if more than one strategy is recommended to address the client's medical issues, the healthcare provider should discuss possible cost/payment issues and options with the client.

Other services client may be eligible for:

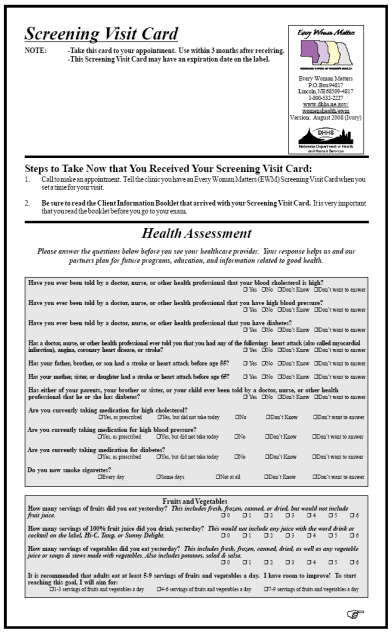
Lifestyle Interventions (LSI's) which refers to giving information to the client about lifestyle changes. Client may receive LSI's according to her lab values as noted below. (See Cardiovascular/Diabetes Protocols Section for more detailed information)

Normal: Refer to no-cost/low-cost community resources

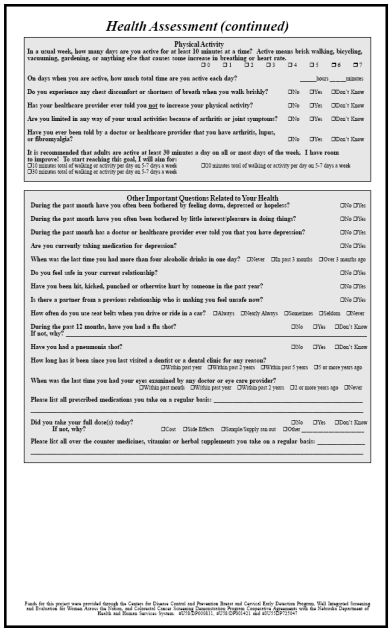
At-risk/Abnormal: 4 month intervention management process with Regional LSI.
Blood pressure of 120-180 systolic or 80-110 diastolic
Fasting total cholesterol of 200-400 mg/dl
Fasting blood glucose 100-375 mg/dl

Alert: 4 month intervention management process with Regional Case Manager
Blood pressure of $\geq$180 systolic or $\geq$110 diastolic
Fasting total cholesterol of $\geq$400 mg/dl
Fasting blood glucose $\geq$375 mg/dl

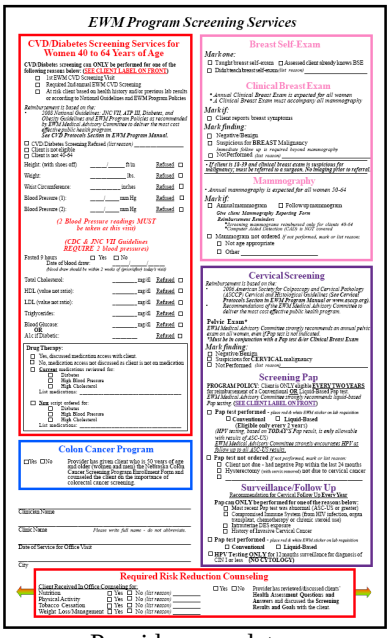
Example forms for Cardiovascular / Diabetes Screening



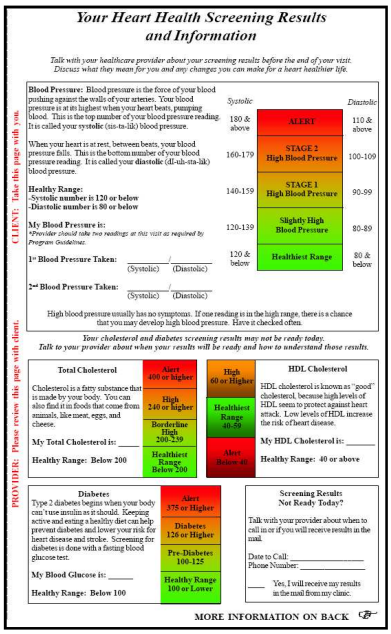
Client completes

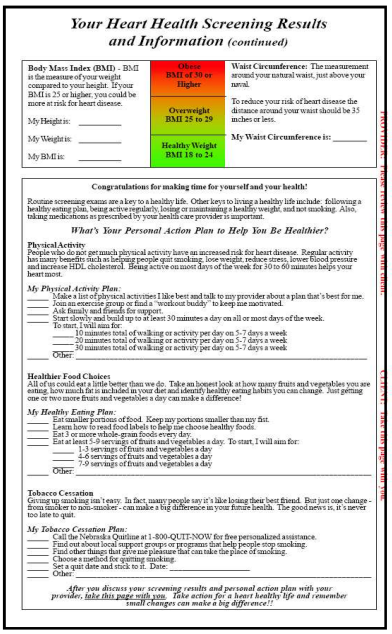


Client completes



Provider completes





Provider and Client completes these two pages together

Screening Visit Card (5 pages)

Other Follow Up Guidelines

Follow Up Timeliness Parameters	Report of Women Deemed Lost to Follow Up	Client's Refusal of Services
The funder of this program, the Centers for Disease Control and Prevention, has set parameters for acceptable timeliness between screening and diagnosis and between diagnosis and treatment. These parameters are: ▪ No more than 60 days should elapse between screening and diagnosis ▪ No more than 60 days should elapse between diagnosis and the initiation of treatment	All providers must make at least three (3) documented attempts at follow up for clients with abnormal results. The documentation must include the dates and types of contact as well as the results of the contact. Once a provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up. **Failure to show up for a scheduled appointment does not constitute lost to follow up.** The provider then notifies EWM of the client's status using the Report of Women Deemed Lost to Follow Up form. EWM then attempts to locate the client to encourage her to return for follow up care. *(Example of Report of Women Deemed Lost to Follow Up form located on page 3-21)*	In the event of client's refusing diagnostic services or treatment services, the healthcare provider should complete the Client Informed Refusal form. Healthcare providers need to fill in the following: client name, date of birth, social security number (if she has one) and the name of the procedure or treatment the client is refusing in the left margin of the form. The form should be given to the client in person or mailed. If mailed, information should be given verbally to the client by phone to ensure that client has enough information to make an informed decision. If client fails to return or sign the Client Informed Refusal, the reverse side of the Client Informed Refusal should be completed by the healthcare provider. This will indicate whether or not the healthcare provider believes the client had enough information to make an informed decision. *(Example of Client Refusal form and the Provider Documentation of Refusal form located on page 3-21)*

Example forms for Other Follow Up

Report of Women Deemed Lost to Follow Up

Every Woman Matters

NEBRASKA

Call us if you have questions.
(800) 532-2227

Reasonable accommodations made for persons with disabilities.
TDD (800) 833-7352

Version: August 2008

⊙ Client only lost to follow up if you cannot locate her. If you know where she is the client is not lost.

Date: ____/____/____ *(Date provider deemed client was lost to follow up)*
Date: ____/____/____ *(Date form completed)*

Provider Name, Clinic Name and City: _____
Please do not abbreviate

Client's Name: _____
If client changed names, please list both names

Client's Social Security #: _____ Client's Date of Birth: ____/____/____

The client is considered lost to follow up when:
1. Contacted by phone and the phone is diroconnected.
2. Current resident of her last known address states that they do not know of such a person or the client no longer lives at the last known address.
3. A letter is sent to the client and it returns with "client moved no forwarding address given" or "forwarding has expired."

Contact Date	Type of Contact	Results	Leads

⊕ *You must make at least three (3) attempts to locate the client before deeming her lost to follow up. Documentation must include the dates and types of contacts, as well as the results of the contact. Once a provider has exhausted all conventional means to contact a client to return for follow up, the client can be deemed lost to follow up. Failure to show up for a scheduled appointment does not constitute lost to follow up.*

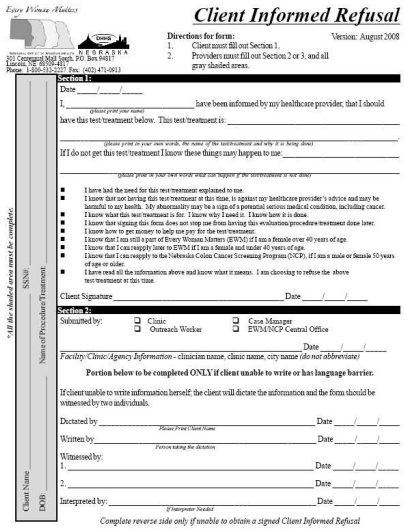
1. _____
_____

2. _____
_____

3. _____

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP003011, #U58/DP003421 and #U57/DP/25047.

Report of Women Deemed Lost to Follow Up



Client Informed Refusal

Every Woman Matters

NEBRASKA

301 Centennial Mall South, P.O. Box 94817
Lincoln, NE 68509-4817
Phone: 1-800-532-2227 Fax: (402) 471-0913

Directions for form: Version: August 2008
1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3, and all gray shaded areas.

Section 1:

Date ____/____/____

I, _____ have been informed by my healthcare provider, that I should
(please print your name)
have this test/treatment below. This test/treatment is: _____

_____
(please print in your own words, the name of the test/treatment and why it is being done)

If I do not get this test/treatment I know these things may happen to me: _____

_____
(please print in your own words what can happen if the test/treatment is not done)

- I have had the need for this test/treatment explained to me.
- I know that not having this test/treatment at this time, is against my healthcare provider's advice and may be harmful to my health. My abnormality may be a sign of a potential serious medical condition, including cancer.
- I know what this test/treatment is for. I know why I need it. I know how it is done.
- I know that signing this form does not stop me from having this evaluation procedure/treatment done later.
- I know how to get money to help me pay for the test/treatment.
- I know that I am still a part of Every Woman Matters (EWM) if I am a female over 40 years of age.
- I know that I can reapply later to EWM if I am a female and under 40 years of age.
- I know that I can reapply to the Nebraska Colon Cancer Screening Program (NCP), if I am a male or female 50 years of age or older.
- I have read all the information above and know what it means. I am choosing to refuse the above test/treatment at this time.

Client Signature _____ Date ____/____/____

Section 2:

Submitted by: ☐ Clinic ☐ Case Manager ☐ Outreach Worker ☐ EWM/NCP Central Office

_____ Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Portion below to be completed ONLY if client unable to write or has language barrier:

If client unable to write information herself, the client will dictate the information and the form should be witnessed by two individuals.

Dictated by _____ Date ____/____/____
Please Print Client Name

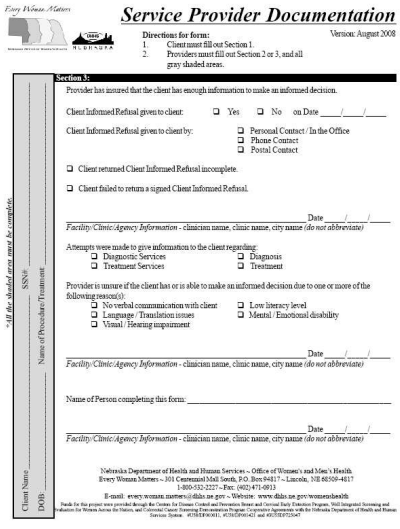
Written by _____ Date ____/____/____
Person taking the dictation

Witnessed by:
1. _____ Date ____/____/____
2. _____ Date ____/____/____

Interpreted by: _____ Date ____/____/____
If Interpreter Needed

Complete reverse side only if unable to obtain a signed Client Informed Refusal

**All the shaded areas must be complete.*
Client Name _____ DOB _____ SSN# _____ Name of Procedure/Treatment _____



Service Provider Documentation

Every Woman Matters

NEBRASKA

Directions for form: Version: August 2008
1. Client must fill out Section 1.
2. Providers must fill out Section 2 or 3, and all gray shaded areas.

Section 3:

Provider has insured that the client has enough information to make an informed decision.

Client Informed Refusal given to client: ☐ Yes ☐ No on Date ____/____/____

Client Informed Refusal given to client by:
☐ Personal Contact / In the Office
☐ Phone Contact
☐ Postal Contact

☐ Client returned Client Informed Refusal incomplete.

☐ Client failed to return a signed Client Informed Refusal.

_____ Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Attempts were made to give information to the client regarding:
☐ Diagnostic Services ☐ Diagnosis
☐ Treatment Services ☐ Treatment

Provider is unsure if the client has or is able to make an informed decision due to one or more of the following reason(s):
☐ No verbal communication with client ☐ Low literacy level
☐ Language / Translation issues ☐ Mental / Emotional disability
☐ Visual / Hearing impairment

_____ Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Name of Person completing this form: _____

_____ Date ____/____/____
Facility/Clinic/Agency Information - clinician name, clinic name, city name *(do not abbreviate)*

Nebraska Department of Health and Human Services – Office of Women's and Men's Health
Every Woman Matters – 301 Centennial Mall South, P.O. Box 94817 – Lincoln, NE 68509-4817
1-800-532-2227 – Fax: (402) 471-0913
E-mail: every.woman.matters@dhhs.ne.gov – Website: www.dhhs.ne.gov/womenshealth

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP003011, #U58/DP003421 and #U57/DP/25047.

**All the shaded areas must be complete.*
Client Name _____ DOB _____ SSN# _____ Name of Procedure/Treatment _____

Client Informed Refusal and Service Provider Documentation